

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

June 11 -62-024280

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 3058
FILED JUN 27 1962

Primary Registration District No. 3058 Registrar's No. 160

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		c. CITY OR TOWN St. Peters	
Length of stay in 1b 5 da.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 1 1/2 so. on Cottleville Rd.	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle F. Last Himmelsbach		4. DATE OF DEATH Month June Day 9 Year 1962	
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-29-1879
9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (City and state or country) O'Fallon, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Raymond Himmelsbach		13b. MOTHER'S MAIDEN NAME Catherine Huber	
14. NAME OF HUSBAND OR WIFE Frances Himmelsbach		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Mo. Frances Himmelsbach, St. Peters	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Gastric Ulcer		INTERVAL BETWEEN ONSET AND DEATH few hrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 6/12/57 to 6/9/62 and last saw her alive on 6/9/62 Death occurred at 6/9/62 - 11 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) O.K. Thiele M.D.	
22b. ADDRESS 340 N. Main - St. Charles, Mo.		22c. DATE SIGNED 6/11/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 6-13-62	23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery	23d. LOCATION (City, town, or county) St. Peters, Mo.
24. FUNERAL DIRECTOR Geo. Stiefvater, St. Peters, Mo.		25. DATE RECD. BY LOCAL REG. 6/11/62	
26. REGISTRAR'S SIGNATURE Marcella Wilson			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

JUN 28 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address O Fallon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.